Mannum Medical

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MANNUM
Phone: 08 8569 0222
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Dr Stephen	**NAPOLI**	MBBS (Adel)	FRACGP DRCOG (Obst) DCH	Provider 2101538A
Dr Sonia	**SCHUTZ**	BMBS	FRACGP, FARGP, DCH, DRANZCOG, Grad Dip Rural, Grad Dip Pall Care	Provider 222715BX
Dr Hamoudi	**ALDYNI**	MBChB	FRACGP	Provider 276888HK
Associates				
Dr Myrtle	**STIBBE**	BMBS		Provider 0434455JY

CONFIDENTIAL

REQUEST TO TRANSFER MEDICAL RECORDS

Date ______________________ Fax: ________________________________

TO: ________________________________ Phone: ______________________________

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We wish to advise that the patient(s) listed below are now attending our medical centre.
To ensure privacy and continuity of care, it is requested that their medical records be transferred to this centre by fax or registered mail. PLEASE DO NOT SEND INFORMATION ON A DISC OR USB.

****We understand that a fee may apply and request that the patient be advised of any fees relating to the copy and transfer of their medical records.****

FULL NAME: **DATE OF BIRTH:** **SIGNATURE:**

CURRENT ADDRESS:

PREVIOUS ADDRESS:

I – the above named person – give consent for a copy of our medical notes to be released to Mannum Medical.

Would you please send a **COPY ONLY** of the above patient/s Health Summary and a **COPY ONLY** of any relevant, specialist investigations, history of chronic or unusual conditions.

We would also appreciate the PLAN history of the patient as listed below:

EPC Item	Completed Yes/No	Date Completed
GPMP Created (item 721)		
TCA Created (item 723)		
Mental Health Plan (item 2700, 2701, 2715, 2717)		

Yours sincerely,

_____________________________ Medical Records Clerk

OFFICE USE

DR ___________

Quality Practice Accreditation
Supporting outstanding general practice